

2004

GEORGIA STATE BOARD OF WORKERS' COMPENSATION
LICENSURE & QUALITY ASSURANCE DIVISION
REHABILITATION SUPPLIER REGISTRATION APPLICATION

PERSONAL DATA

NAME _____
(LAST) (FIRST) (MIDDLE)

ADDRESS _____

(CITY) (STATE) (ZIP)

PHONE# () _____ FAX# () _____

INTERNET E-MAIL _____ SS# _____

EMPLOYER: _____

ADDRESS: _____

CITY STATE ZIP PHONE: _____

ADDRESS & PHONE NUMBER FOR BOARD CORRESPONDENCE:

PHONE NUMBER

Mailing Address City State Zip

ANY CHANGE OF ADDRESS, PHONE NUMBER, OR E-MAIL ADDRESS MUST BE REPORTED TO THE LICENSURE & QUALITY ASSURANCE DIVISION OF THE STATE BOARD OF WORKERS' COMPENSATION. CHANGES SENT TO OTHER DIVISIONS WILL NOT BE PROCESSED.

GENERAL DATA

DO YOU SPEAK OR WRITE IN A FOREIGN LANGUAGE? _____

IF YES, STATE LANGUAGE AND NUMBER OF YEARS: _____

ARE YOU ABLE TO COMMUNICATE WITH THE DEAF IN SIGN LANGUAGE? _____

HAVE YOU BEEN CERTIFIED OR REGISTERED AS A SUPPLIER BEFORE? _____

IF YES, STATE THE SUPPLIER NUMBER ASSIGNED: _____

WERE YOU REGISTERED IN ANY OTHER NAME? _____

IF YES, STATE THE NAME (S): _____

EDUCATIONAL DATA	
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[illegible]

EMPLOYMENT DATA - ATTACHING A RESUME IS NOT ACCEPTABLE

DESCRIBE YOUR WORK HISTORY BEGINNING WITH YOUR CURRENT OR MOST RECENT JOB. DESCRIBE IN DETAIL THE SPECIFIC DUTIES AND RESPONSIBILITIES FOR EACH JOB.

EMPLOYER: _____

ADDRESS: _____

PHONE: _____ NAME OF SUPERVISOR: _____

DATES FROM AND TO: _____ JOB TITLE: _____

DUTIES:

EMPLOYER: _____

ADDRESS: _____

PHONE: _____ NAME OF SUPERVISOR: _____

DATES FROM AND TO: _____ JOB TITLE: _____

DUTIES:

EMPLOYER: _____

ADDRESS: _____

PHONE: _____ NAME OF SUPERVISOR: _____

DATES FROM AND TO: _____ JOB TITLE: _____

DUTIES:

HAVE YOU EVER HAD ANY BUSINESS OR PROFESSIONAL LICENSE REVOKED,
SUSPENDED, OR ANNULLED OR HAD ANY OTHER DISCIPLINARY ACTION TAKEN
AGAINST YOU?

IF YES, EXPLAIN _____

WILL YOUR PRINCIPAL PLACE OF BUSINESS BE WITHIN THE STATE OF GEORGIA?

HAVE YOU EVER BEEN CONVICTED OF ANY CRIME OR PLED NOLO CONTENDRE IN A
CRIMINAL PROCEEDING?

IF YES, EXPLAIN _____

I HAVE READ, AND AM AWARE OF, O.C.G.A. 34-9-200.1 AND RULE 200.1. ALL OF
THE INFORMATION ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE
THE STATE BOARD OF WORKERS' COMPENSATION TO MAKE ANY INVESTIGATION OF THE
FOREGOING INFORMATION. I UNDERSTAND THAT ANY OMISSION OR MISREPRESENTATION
MAY RESULT IN REJECTION OR REVOCATION OF REGISTRATION.

SIGNATURE _____ **DATE** _____

NOTARY _____ **EXPIRATION DATE** _____

RETURN NOTARIZED APPLICATION AND CHECK OR MONEY ORDER (IN THE
AMOUNT OF \$100.00, ALONG WITH CERTIFICATION (S) TO:

GEORGIA STATE BOARD OF WORKERS' COMPENSATION
LICENSURE & QUALITY ASSURANCE DIVISION
270 PEACHTREE STREET NW
ATLANTA, GA 30303-1299

GA STATE BOARD OF WORKERS COMPENSATION

REHABILITATION REGISTRATION APPLICATION

INSTRUCTIONS AND INFORMATION

CERTIFICATION REQUIREMENTS

A **REHABILITATION SUPPLIER** SHALL HOLD ONE OF THE FOLLOWING CERTIFICATIONS OR LICENSES.

Please submit:(1) the notarized application, and (2) certification or evidence of professional licensure by the State of Georgia or official certified post secondary academic transcripts. Rule 200.1(f)(2). (3) registration fee of \$100.00.

CRC - Certified Rehabilitation Counselor
CDMS - Certified Disability Management Specialist
CWAVES - Certified Work Adjustment & Vocational Evaluation Specialist
CRRN - Certified Registered Rehabilitation Nurse Program
LPC - Licensed Professional Counselor
CCM - Certified Case Manager
COHN - Certified Occupational Health Nurse
COHN-S - Certified Occupational Health Nurse - Specialist

A **Resident Rehabilitation Supplier** shall (1)submit documentation showing that they are scheduled to sit for the examination for CDMS, CRRN, LPC, CWAVES or CRC, (2) the notarized application and (3) academic transcript(s) Rule 200.1(f)(3) Registration fee of \$100.00.

RETURN APPLICATION, CERTIFICATES, TRANSCRIPTS AND \$100.00 CHECK OR MONEY ORDER TO:

STATE BOARD OF WORKERS' COMPENSATION
LICENSURE AND QUALITY ASSURANCE DIVISION
270 PEACHTREE STREET NW
ATLANTA, GA 30303-1299
404/656-3559